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VS A15 (4) 15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18 8927

CERTIFICATE OF DEATH

118899

| | | | 18 | - | - |
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| -0 | Dist | No | | | |

| | | COUNTY | Pout (| 30. | MAR | YLAND 2. | USUAL RESIDEN o. STATE Ma.r. | vlan | | lived. If instituti b. COUNTY | on: Residence | | idmission) |
|---|-----------------|--------------------------------------|-------------------------------------|--------------|--------------------|--------------|-------------------------------------|------------|------------------------|----------------------------------|---------------|------------|---------------|
| | - | . CITY OR TOWN (II | f outside carporate lim | its, write | c. LENGTH OF STAY | Y IN 1b | c. CITY OR TOV | VN (If out | side corpora | ite limits, write R | | | town) |
| | - | Pricence | 0 1 0 1 | 1.15. | | | La Pl | ata | | 0 | 5 x- | 0 | |
| | , | . NAME OF HOSPIT | AL (If nat in hospital, | give street | oddress) | | d. STREET ADD | | | | | e. 1 | S RESIDENCE |
| | 0 | OR INSTITUTION | ursing | H | ome, | | | | | | | | ON A FARM? |
| | 1 | NAME OF DECEASED (Type or print) | KARA | rst | Middle DECELTA | e | COBBO | NS | 4. DATE OF DEATH | aua | ith | Day /2 | Year 195 9 |
| | 5. 5 | EX | 6. COLOR OR RACE | T - | RIED NEVER MARR | IED B. C | ATE OF BIRTH | 1 | 9 | AGE (In years last birthday) | IF UNDER | 1 YEAR IF | UNDER 24 HRS. |
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| | 10a | Female USUAL OCCUPATION | Nhite N (Give kind of work | 1 | Park h | - 0 | 11y 29 | 188 | | | 12 CIT | IZENI OE V | VHAT COUNTRY? |
| | | during most of work | ing life, even it refired |) | | OK 1110031K1 | TT. DIKITII DACI | (31010-01 | Toreign coo | ,, | 12. 611 | IZEIN OF V | THAT COUNTRY |
| 9 | | House w | ife | A | t Home | | | | | ryland | | J.S.A | • |
| Н | 13. | FATHER'S NAME | | | | | 4. MOTHER'S MA | AIDEN NA | ME | | | | |
| | | Simon | Bowie | | | | Marv | C. I | Burges | 88 | | | |
| | 15. | WAS DECEASED EVER | R IN U. S. ARMED FOR | CES? 16. | SOCIAL SECURITY NO | D. 17. INFO | | | | Add | ress | | |
| | 1.0 | No | it yes, give war or dates or | an vice) | No | Mice | Jennie | PI | Bowie | . L. D1 | ata | Md. | |
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| | | lying cause last. |) (0 | :) | / | | | | | | | | |
| | ŏ | PART II. OTH | ER SIGNIFICANT CON | DITIONS | CONTRIBUTING TO DE | ATH BUT NO | T RELATED TO TH | ETERMINA | AL DISEASE | CONDITION GIV | EN IN PART | 1(o) 19. V | VAS AUTOPSY |
|) | SAT | | | | | | | | | | | | ERFORMED? |
| | TIFIC | 20a. ACCIDENT WA | S UNDERLYING | 20b. DES | CRIBE HOW INJURY O | OCCURRED. (E | inter nature af in | jury in Po | rt I or Port I | l af item 18.) | | | |
| | L CERTIFICATION | (IF EITHER, NOTIFY | CAUSE OF DEATH MEDICAL EXAMINER) | | | | | | | | | | |
| | MEDICAL | 20c. TIME OF INJURY Haur o. m. | Y Manth, Day, Ye | | NJURY OCCURRED | 20e. PLACE | OF INJURY (Hone, street, office ble | ne, farm, | 20f. (City o | r town) | (C | County) | (Stote) |
| | MEC | p. m. | 19 | While of wor | k ot work | X | , | agi, eic.j | _ | | | | |
| | | 27 I cortific the | at attended the | doceas | ed from | 17/ | 105 4 | - F | 1/1. | 7 10 (| Ab ma 1 1 | | the deceased |
| | | | ar I direilded lile | . 19 / | 1 41 | | | u | 1. 1. | / | | | |
| | | alive on | 5 | 1 2 | , ana/mai | r dearn ac | curred at | | | the causes of the city or town, | | ne date : | stated abave |
| я | | ACTUAL | inc KI | 1. 1 | 1- | | 17. | | DRESS (SITE | ei, city or iown, | n / | | DATE SIGNED |
| | | SIGNATURE | 11 | C/A | | M.D | Mul | 1.66 | | PACTO | C-FZ | | 112/2 |
| | | PHYSICIAN'S NAME (Type) | PAGE! | 1. 5 | SETT | | (XA | dw | ME | 701 | TA TOT | 100 | ~ / |
| | 22a | BURIAL, CREMATION | N, 226. DATE THEREC |)F | 22c. NAME OF CEM | AETERY OR CI | REMATORY | 2 | 2d. LOCATIO | ON (City, town, | or county) | | (Stote) |
| | I | REMOVAL (Specify) | 18/45/195 | 91 | Mt. Rost | Cemete | rv | | La P | lata . | Marvla | and | |
| - | -www. | FUNERAL DIRECTOR | | 17 | ADDRESS | - Cincon | | a. REC'D | BY REGISTRA | | STRAR'S SIG | | |
| | | (heha) | | (11 | ome, on | 1 | | | 1 8 '59 | | Jan S. | | |
| | /- | REHART FU | NERAL HOME | IN | IC * LA PI | LATA | MT) | ATEAUG | 1000 | | (AG . 1 | 35440- | |

ST EXCHANGES BY LASH BO THE MYRASH SHATE CHAINSAN

may be retained by the haspital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by me funeral director, page 3 shauld be detached far use as the burial-transit permit. Then please removeraban papers. Pages 1 and 2 should be filed with, the registrar prior to burial, cremation, or remaval, and in any event within 72 hours after death.

TTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours

death, Page 4

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8928 **CERTIFICATE OF DEATH**

Reg. Dist. No.

| 0 | 8 | 9 | Ü | 0 |
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| 1. PLACE OF DEATH O. COUNTY Calree & MARYLAND | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE b. COUNTY Carree |
|--|--|
| b. CITY OR TOWN (If outside corporate limits, write RUPAL and give nearest flown) | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) |
| d. NAME OF HOSPITAL (If not in hospital, give street oddress) OR INSSITUTION, Personne Thomas | d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES \(\sum NO \(\sum \) |
| 3. NAME OF DECEASED (Type or print) ROSY FIRST Middle | GOTT A. DATE Month Day Year OF DEATH Que 27, 1259 |
| 5. SEX 6. COLOR OR FACE 7. MARRIED NEVER MARRIED WIDOWED DIVORCED D | B. DATE OF BIRTH 9. AGE (In years WUNDER 1 YEAR IF UNDER 24 HRS. Manths Days Hours Min. 1. 27 1880 Min. Min. |
| 100. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unsumployed | STRY 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY Cabrell 6. Med 26. S. G. |
| John T. Sott | 14. MOTHER'S MAIDEN NAME Usabelle Boyd |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. (Yes, fro., for unknown) (If yes, give wor or dotes of service) | in favrence Harrison - Dwings , het |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | calan Reval Design Interval Between ONSET AND DEATH |
| Conditions, if any, which) (b) | |
| gove rise to immediate couse (a), stating the <u>under-lying couse last.</u> DUE TO (c) | |
| CATIO | T NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPSY PERFORMED? YES NO |
| 200. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRE OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | D. (Enter nature of injury in Port I or Part II of item 18.) |
| | ACE OF INJURY (Home, form, 20f, (City or town) (County) (Stote) ctory, street, office bldg., etc.) |
| 21. I certify that I attended the deceased from alive an 21. 19 957 and that death | accurred atM, fram the causes and an the date stated above |
| ACTUAL SIGNATURE IL WILL KAND | ADDRESS (Street, city or town, stote) DATE SIGNE STag [5] |
| PHYSICIAN'S H. W. WARD | OWINGS MO |
| 220. BURIAL CREMATION, 226. DATE THEREOF 22c. NAME OF CEMETERY OF SWELCH STORY OF WATER MEN | OR CREMATORY 22d. LOCATION (City, town, or county) (Stole) |
| 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS ADDRESS ADDRESS Multip | 240. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE Online SEP 1 '59 Online & House |
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MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

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| 0 | - | V | V | A. |

8929 CERTIFICATE OF DEATH Reg. Dist. No. 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived. If institution: Residente o. COUNTY o. STATES b. COUNTY MARYLAND b. CITY OR TOWN (If outside carporote limits, write c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) RURAL and give nearest town) d. NAME OF HOSPITAL (If not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE OR INSTITUTION ON A FARM? YES NO D 3. NAME OF First Middle DATE last Day Year DECEASED DEATH (Type or print) 19 0 6. COLOR OR RACE 7. MARRIED NEVER MARRIED B. DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS last birthdoy) Months Min. WIDOWED [DIVORCED T USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (Stote or foreign cauntry) during most of working life, even if retired) 12. CITIZEN OF WHAT COUNTRY? 13 FATHER'S NAME 14. MOTHER'S MAIDEN NAME ARMED FORCES? 17 INFORMANT 16. SOCIAL SECURITY NO. Address 18. CAUSE OF DEATH [Enter only one couse per line for (o), (b), and (c) INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY das IMMEDIATE CAUSE (o DUE TO Conditions, if ony, which gave rise to immediate DUE-TO cause (a), stating the underlying couse lost PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(9) WAS AUTOPS PERFORMED? YES NO 200. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I ar Part II af item 18.) 20e. PLACE OF INJURY (Home, form, 20f. (City or town) 20c. TIME OF INJURY Month. Day, Year 20d. INJURY OCCURRED (Stote) (County) factory, street, office bldg., etc.) Hour o. m While Not while of work of work p. m 21. I certify that I attended the deceased from Ithat I last saw the deceased alive an and that death occurred at M, fram the causes and on the date stated above. ADDRESS (Street, city or Jown, state) DATE SIGNED ACTUAL PHYSICIAN'S NAME (Type) 220. BURLAL CREMATION 226 DAJE THEREOF 22c. NAME OF CEMETERY OR CREMATORY 22d. LOCATION (City, town, or county) (State) 23 FUNERAL DIRECTOR'S SIGNATURE **ADDRESS** 240. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE

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VS A15 (4) 15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 8930 **CERTIFICATE OF DEATH**

08902 Rea. Dist. No.

| | | | | | mag. with | | |
|---|---|---|------------------------|------------------------------|--------------------------|--------------|--------------------|
| 1. PLACE OF DEATH o. COUNTY Calvert | MARYLAND | 2. USUAL RESIDENCE (W o. STATE Maryland | here deceased | b. COUNTY | on: Residence b | efore admiss | sion) |
| b. CITY OR TOWN (If outside corporate limits, RURAL and give nearest town) Prince Frederick | write c. LENGTH OF STAY IN 16 | c. CITY OR TOWN (II | autside carpora | ote limits, write R | URAL ond give | nearest town | n) |
| d. NAME OF HOSPITAL (If not in hospital, give OR INSTITUTION Calvert County Hosp | | d. STREET ADDRESS | | | | | SIDENCE A FARM? |
| 3. NAME OF DECEASED (Type or print) A Frank Johns | Middle on. Jr. | Lost | 4. DATE OF DEATH | August | | | Yeor 19 59 |
| | MARRIED NEVER MARRIED DIVORCED DIVORCED | 8. DATE OF BIRTH February 24. | 1928 | AGE (In years lost birthdoy) | IF UNDER 1 YE Months Day | | ER 24 HRS. Min. |
| 10a. USUAL OCCUPATION (Give kind of work dor during most of working life, even if retired) | e 10b. KIND OF BUSINESS OR INDU | STRY 11. BIRTHPLACE (Stote | or foreign cou | | | OF WHAT | COUNTRY |
| 13. FATHER'S NAME | | Maryland 14. MOTHER'S MAIDEN | NAME | | 1 0.5 | A. | |
| Vincent Johnson | | Christine | Philip | 0 | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCE: (Yes, no. or unknown) (If yes, give war or dotes of serve | (0) | NFORMANT | | Addi | ress | | |
| | | ruzila Johnso | n, Oliv | vet, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one couse PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) DUE TO | per line for (o), (b), and (c). | ilusp | Luc | 5 | O O | NTERVAL BE | DEATH |
| Conditions, if ony, which gove rise to immediate couse (a), stating the <u>under-lying</u> couse lost. (c) | Conneg and | of the | | | | | |
| PART II. OTHER SIGNIFICANT CONDIT | IONS <u>CONTRIBUTING TO DEATH</u> BUT | NOT RELATED TO THE TERM | INAL DISEASE | CONDITION GIV | EN IN PART 1(o | PERFO | AUTOPSY ORMED? |
| (IF EITHER, NOTIFY MEDICAL EXAMINER) | b. DESCRIBE HOW INJURY OCCURRE | D. (Enter nature of injury in | Port I or Part I | 1 of item 18.) | | | |
| 20c. TIME OF INJURY Month, Doy, Year Hour o. m. 19 | 20d. INJURY OCCURRED While Not while for or work of or or work | ACE OF INJURY (Home, forn clary, street, office bldg., etc | n, 20f. (City o | ir town) | (Count | ly) | (Stole) |
| 21. I certify that I attended the de | eceased from | , 19, to | lug? | 193 | thot I last | saw the | decease |
| alive on | 19 and that death | occurred ot | M fram | the couses o | nd on the c | date state | ed above |
| ACTUAL SIGNATURE SIGNATURE | ellagran | M.D. 57 | ADDRESS (Sye | et, city or town, | stote | 8 | TE SIGNE |
| PHYSICIAN'S NAME (Type) Roberto de Vi | Harreal, M. D. | St. Leon | ard, Mo | i. | | 7 | / |
| 220 BURIAL CREMATION, 22b. DATE THEREOF REMOVAL (Specify) | 22c. NAME OF CEMETERY O | R CREMATORY | 22d. LOCATIO | ON (City, lown, o | or county) | (Stot | e) |
| 0-28,59 | 9t. John | 130 | | ibes, | | m | d |
| 23. FUNERAL DIRECTOR'S SIGNATURE | ADDRESS | 24a. REC' | D BY REGISTRA | AR 24b. REGIS | TRAR'S SIGNAT | TURE | |
| P. C. Derevell Mr. | Treel, mid. | DATE | rn 2 15 | 0 0 | -1 01 | , | |

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MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Reg. Dist. No. cremoffen 2. USUAL RESIDENCE JAVING discessed lived. If Institution: Avaidence between 1 PLACE OF DEATH a. COUNTY Q. STATE b. COUNTY MARYLAND buricl, b. CITY OR TOWN (If outside cosposate limits, write RURAL) c. CIPY OR TOWN Alf outside corposate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b 0 d. STREET ADDRESS . IS RESIDENCE d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) prior ON A FARM? YES NO NO retained for your fill NAME OF Middle DATE **First** Year DECEASED DEATH (Type or print) 19 5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 1 B. DATE OF BIRTH! 9. AGE (In years IFUNDER TYEAR IF UNDER 24 HRS. the Months Days Hours Min. WIDOWED [7] DIVORCED T yes. 10a. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRY during most of working life, even if retired) 11. BIRTHPLACE/(State or foreign country) 12. CITIZEN OF WHAT COUNTRY? puo ron 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. Address 17. INFORMANT (If yes, give war or dates of service) Give PM3. INTERVAL BETWEEN 18. CAUSE OF DEATH [Enter only one cause per line for to), (b), and (c). ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate couse along **DUE TO** (a), stating the underlying cause last. 0 pending in PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1101 19. WAS AUTOPSY 00 PERFORMED? used NO T 20g. EXTERNAL CAUSE WAS 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in fort or Fort 11 of item 18.) PRIMARY | or CONTRIBUTING | CAUSE OF DEATH. cute the certificate, writing the ward forwarded to the Chief Medical Exami 20e. PLACE OF INJURY (Home, form, inctory street, offici bldg., etc.) 20f (Lity of town) 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED (Stote) While at work at work 21. I certify that I taak charge of the remains described above, held an Allopsy Inspection Inquiry . ond find that Accident Suicide . death resulted fram: Natural causes , Hamicide . Undetermined cause DATE SIGNED ACTUAL CHIEF MEDICAL EXAMINER SIGNATURE ASSISTANT MEDICAL EXAMINER **EXAMINER'S** DEPUTY MEDICAL EXAMINER NAME (Type) 220 BURIAL CREMATION, 22b, DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORY 22d. LOCATION (City, town, or county) (State) REMOVAL (Specify) 0 ADDRESS 23. FUMERAL DIRECTOR'S SIGNATURE 24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE VS. A15ME(5) arthur & House 5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18 Reg. Dist. No. e. IS RESIDENCE ON A FARM? YES NO Day Year 19 IF UNDER TYEAR IF UNDER 24 HRS Months Days Hours 12. CITIZEN OF WHAT COUNTRY? PERFORMED? NO T (County) 1Stote

Inquiry

a'no & Travers

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and find that

DATE SIGNED

(State)

VS. A15ME(S) 5M 9/55

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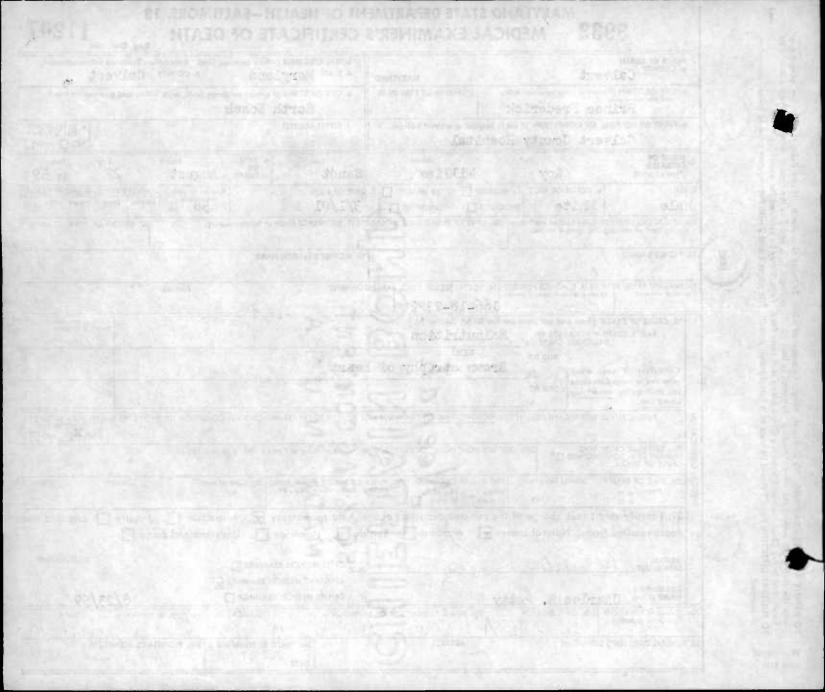
MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18 8933 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11207 Reg. Dist. No.

| 1. PLACE O | F DEATH TY Calver | t | | MAI | RYLAND | 2. USUAL RESIDENCE O. STATE Mar | | | nstituti | | once be | | ission) |
|--|---|--|-------------|---------------------------------|--------------------|---|--|------------------------------|----------|-----------|---------------|------------------|--------------------|
| b. CITY O and give | re negrest town) | Frederi | | c. LENGTH OF STA | Y IN 1b | c. CITY OR TOW | N (If outside cor | | write R | RURAL one | d give n | earest to | wn) |
| d. NAME | | t County | | pital, give street oddr ital | 'ess) | d. STREET ADDRE | SS | | | | | ON | A FARM? |
| 3. NAME O DECEASE (Type or) | D | Roy | | William Middle | | Sandt | 4. DATE OF DEATH | Augus | Month | 1 | Day 22 | | 7ear 19 59 |
| 5. SEX | | olor or race | 7. MARRIE | DIVORCE | | 3/1/01 | | 9. AGE (In yet lost bighday) | yrs, | Months | 1YEAR Doys | IF UND Hours | ER 24 HRS. Min. |
| 10a. USUAL during me | OCCUPATION (G st of working life, | ive kind of work d even if retired) | lone 10b. K | IND OF BUSINESS O | R INDUST | RY 11. BIRTHPLACE (S | State or foreign o | country) | | 12. CIT | IZEN O | F WHAT | COUNTRY? |
| 13. FATHER | SNAME | | | | | 14. MOTHER'S MAID | EN NAME | | | | | | |
| 15. WAS DE (Yes, no, or unk | | U. S. ARMED FOR give wor or dates of s | ervice) | SOCIAL SECURITY NO 6-18-2322 |). 17. IN | FORMANT | | Add | dress | | | | |
| Conditi gave ris (o), sta cause I | 22, 2, ions, if ony, we to immediate of ting the underlost. | ying DUE TO (c)_ | | and an atrophy | | heart OT RELATED TO THE T | FRMINAI DISEAS | E CONDITION | GIVE | N IN PAR | Timil | o was | AUTOPSY |
| 20g. EXT PRIMARY | ERNAL CAUSE W | AS 20t | | | | nter noture of injury in | | | | | | PERFO YES (1) | NO [|
| 0 | E OF INJURY | Month, Day, Year | While | | 20e. PLAC facto | E OF INJURY (Home, ry, street, office bldg., | farm, 20f. (City | y or town) | | (Co | unty) | 3 | (State) |
| | resulted fram | taak charge n: Natural c | _ | -/- | | | cide [], U | ndetermine | | | | | find that |
| SIGNAT EXAMINAME | VER'S | les S. P | ot.tv | etty. | | ASSISTANT ME | AL EXAMINER [] EDICAL EXAMINE CAL EXAMINER [| R 🙀 | | R | /22 | /50 | |
| 220. BURIAL | | D 116 | | U, O W | TER OR | red John | 22d. LOCA | TIONICIA | wo, or | county) | 7 | (Stat | 1. |
| 23. FUNERAL | DIRECTOR'S SIG | NATURE | | ADDRESS | | 240. | OCT 2 1 | RAR 24b. F | | RAR'S SIG | MATU | _ | |

VS. A15ME(5) 5M 9/55

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er death. Page 4

TTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 haurs

TO HOSPITAL

VS A15 (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 8934 **CERTIFICATE OF DEATH**

08905 Reg. Dist. No.

| 1. PLACE OF DEATH o. COUNTY Colore of MARY | LAND 2. USUAL RESIDENCE (Where deceased lived, o. STATE Mary Land) | If institution: Residence before admission) COUNTY (alone f |
|--|--|---|
| b. CITY OR TOWN (If autiside corporate limits, write RURAL and give nearest town) Treature to the state of t | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | d. STREET ADDRESS | e. 15 RESIDENCE ON A FARM? YES NO |
| 3. NAME OF DECEASED (Type or print) First CARLTON | S CRIVENER OF DEATH | Month Doy Year Osea, 29, 1959 |
| 5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED DIVORCE | 00 nov. 10, 1878 8 | (In years IFUNDER 1 YEAR IF UNDER 24 HRS. Months Days Haurs Min. |
| 100. USUAL OCCUPATION (Give kind of work done during most of yorking life, even it retired) Farm Curry Tarm | Cabretto, Ins | 12. CITIZEN OF WHAT COUNTRY? |
| Charles W. Serinener | Christiana V. K | ellon |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes. no or unknown) (If yes, give wor or dates of service) 217-36-71 | 19 Maurica Cerineris - | Catourville, Ind |
| 18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PRODUCTION IMMEDIATE CAUSE (b) | time - Delydrah | INTERVAL BETWEEN ONSET AND DEATH |
| Conditions, if any, which) (b) | ia | 6 months |
| gove rise to immediate cause (a), stating the under-lying cause last. DUE TO - Mendo | ally disturbance | ~ |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DE | ATH BUT NOT RELATED TO THE TERMINAL DISEASE COND | TION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES NO |
| OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | CCURRED. (Enter nature of injury in Part I or Part II of ite | m 18.) |
| 20c. TIME OF INJURY Manth, Day, Year 20d. INJURY OCCURRED While Nat while at work at work | 20e. PLACE OF INJURY (Home, form, factory, street, affice bldg., etc.) |) (County) (State) |
| 21. I certify that I attended the deceased from low alive an | death accurred at M. from the c | , 19.5., that I last saw the deceased auses and an the date stated above. |
| ACTUAL SIGNATURE PROPERTY SIGNATURE | ADDRESS (Street, city | |
| PHYSICIAN'S NAME (Type) | 12 CARREAC. | AD P |
| 220. BURIAL, CREMATION, 22b. DATE THEREOF 22c. NAME OF CEMBER OF CENTRAL CENTRAL | Cemetery Barston | ty. town, or county) (State) |
| 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS - Mules | al, high DATE SEP 1'59 | 246. REGISTRAR'S SIGNATURE |

MARYLAND STATE DEPARTMENT OF HEALTH-SALTIMORE, TO

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| | STATE DEPARTMENT | OF HEALTH- | -BALTIMORE, | 18 |
|------|------------------|------------|-------------|----|
| 8936 | CERTIFICATE | OF DEATH | | |

08907

| | Keg. Dist. No. |
|--|--|
| 1. PLACE OF DEATH O. COUNTY MARYLAND | USUAL RESIDENCE (Where deceosed lived. If institution: Residence before admission) o. STATE b, COUNTY |
| Cattlett | maryland colvert |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) |
| Port-Republic | X Port Republica |
| d. NAME OF HOSPITAL (If not in hospital, give street address) | d. STREET ADDRESS e. IS RESIDENCE |
| OR INSTITUTION | ON A FARM? YES NO |
| 3. NAME OF First Middle | Lost 4. DATE Month Day Year |
| (Type or print) John G.L. 'CL | 40 Wall DEATH 8 15 1959 |
| | B. DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. |
| m. C WIDOWED DIVORCED | lost birthdoy) Months Days Hours Min. |
| | 7an, 29, 58 1 yrs. 6 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | STRY 11. BIRTHPLACE (Stote or foreign country) 12. CITIZEN OF WHAT COUNTRY? |
| | maryland. |
| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
| John Wall, | Ella Hurrod. |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. II (Yes, no. or unknown) 1 (If yes, give wor or dates of service) | NFORMANT Address |
| 3 | lla Harred, Port-Republic |
| 18. CAUSE OF DEATH [Enter only one couse per line for (o), (b), and (c).] | INTERVAL BETWEEN |
| PART I. DEATH WAS CAUSED BY: | ONSET AND DEATH |
| 056.0 DUE TO | to of a |
| DUE TO | |
| Conditions, if ony, which) (b) | |
| gave rise to immediate coese (a), stating the under- | |
| lying couse last. (c) | |
| | NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY |
| E Communication of the communi | PERFORMED? |
| 8 | YES NO |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT 20a. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | D. (Enter nature of injury in Port I or Part II of item 18.) |
| 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED Hour a. m. p. m. 19 While Not while of work of work | ACE OF INJURY (Hame, farm, 20f. (City or town) (County) (State) |
| Hour a. m. While Not while fac | ctory, street, office bldg., etc.) |
| p. m. 19 of work of work | |
| 21. I certify that I ottended the deceased from 6 - 8 | 1959, to 8-11, 1959, that I last saw the deceased |
| alive on FT 114 12 1959, and that death | occurred at 2 P. M. from the couses and on the date stated above. |
| dive on a mor deom | ADDRESS (Street, ply or town, stote) ATE SIGNED |
| ACTUAL 7/ 1/100 110-6 | West Ville Ville Completion |
| SIGNATURE / / / / / / / / / / / / / / / / / / / | M.O. Mulling dun 119 |
| PHYSICIAN'S NAME (Type) | |
| | COCCUSOR MILECUSOR CONTRACTOR CON |
| REMOVAL (Specify) | R CREMATORY 22d. LOCATION (City, town, or county) (State) |
| 18-16,59 Drown | s Port Republic, md, |
| 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS | 240. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE |
| P. E. Sowell, Brunce Fred. | MC DATE AUG 1 8 '59 Chilun S. Krous |

WARFFLARE STATE DEPARTMENT OF HEALTH -BALTIMORE -18

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08908

Reg. Dist. No. PLACE OF DEATH/ 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. COUNTY a. STATE b. COUNTY MARYLAND b. CID OR TOWN (If surhide corporate limits, Arite RUBAL c. CITY OR TOWN (If outside corporate limits, write RURAL and give necrest town) A. LENGTH OF STAY IN 16 STREET ADDRESS d_NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) e. IS RESIDENCE ON A FARM? YES NO 3. NAME OF Middle DATE Year. DECEASED (Type or print) DEATH 5. SEX 6. COLOR OR RACE MARRIED NEVER MARRIED DE BATE OF BIRTH 9. AGE (In years IF UNDER TYPAR IF UNDER 24 HRS Months Days Hours Min. WIDOWED DIVORCED yrs. 10a. USCAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRY during most of working life, even if retired) BIRTHPLACE (State or foreign country) 12. CUIZEN OF WHAT COUNTRY? FATHER'S HAME 14. MOTHER'S MAIDEN NAME 12 INFORMAN WAS DECEASED EVER IN U. S. ARMED FORGES? 16. SOCIAL SECURITY NO. Address 18. CAUSE OF DEATH [Enler only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 260 X **DUE TO** Canditions, if any, which gove rise to immediate cause DUE TO (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE FERMINAL DISEASE CONDITION GIVEN IN PART IO WAS AUTOPSY 20a. EXTERNAL CAUSE WAS 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Part II of item 18.) PRIMARY OF CONTRIBUTING CAUSE OF DEATH. 20c. TIME OF INJURY Mogth, Day, Year 20e. PLACE OF INJURY (Home, form, 20f. (City) of roctory, street, of the bldg., etc.) 20d. INJURY OCCURRED (County) (Stote) at work p. m. 21. I certify that I taak charge of the remains described above, held an Autapsy Inspection Inquiry and find that death resulted from: Natural causes Accident . Suicide Hamicide Undetermined cause DATE SIGNED ACTUAL CHIEF MEDICAL EXAMINER SIGNATURE M.D. ASSISTANT MEDICAL EXAMINER **EXAMINER'S** NAME (Type) DEPUTY MEDICAL EXAMINER 22a. BURIAL CREMATION, 22b. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORY 22d. LOCATION (City, town, or county) (State) Burial (Specify) Cedar Hill Cem. Suitland Md. 23. FUNERAL DIRECTOR'S SIGNATURE 746. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE arthur S. Kraus DATE ALLG 1 8 '59

MARYANDSTATE DEPARTMENT OF HEALTH-SALTINORE, 16
8937 MEDICAL EXAMINER'S CENTIFICATE OF DEATH
RULL OF DEATH

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